TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-1687-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $98.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 93005 has status indicator (SI) Q1 . . . Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator 'S,' 'T,' or 'V.' The requestor billed codes 26765 and 11760 on the same date. the SI for these codes is T. Thus, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2016	Hospital Outpatient Services	$98.62	$7.41

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.)
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 615 – PAYMENT FOR THIS SERVICE HAS BEEN REDUCED ACCORDING TO THE MEDICARE MULTIPLE SURGERY GUIDELINES.
   - 616 – THIS CODE HAS A STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE3
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 725 – APPROVED NON NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153 (C).
   - 767 – REIMBURSED PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Separate reimbursement for implantables was not requested.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

2. Reimbursement for the disputed services is calculated as follows:

   - Procedure codes A6222, 94760, J2765, J2250, J0690, J2405, J1885, J2001 and J3010 have status indicator N denoting packaged codes with no separate payment — these items are integral to the total service package; reimbursement for these items is included in the payment for the primary service(s).

   - Procedure codes 80048 and 85027 have status indicator Q4 denoting packaged laboratory services. Reimbursement for these services is included in the payment for procedure codes 11760 and 26765 billed on the same claim. Separate payment is not recommended.

   - Procedure code 26765 has status indicator T denoting a significant procedure subject to multiple-procedure payment reduction. The highest paying status T procedure is paid at 100%; any others are paid at 50%. This procedure is the highest paying such procedure performed and is paid at 100%. The assigned APC is 5121, which, per OPPS Addendum A, has a payment of $1,455.26, multiplied by 60% yields an unadjusted labor-related amount of $873.16. This amount multiplied by the facility's annual wage index of 0.8026 yields an adjusted labor-related amount of $700.80. The non-labor related portion is 40% of the APC rate, or $582.10. The sum of the labor and non-labor related amounts is $1,282.90. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment amount is $0. The Medicare facility specific reimbursement is $1,282.90. This amount multiplied by 200% yields a MAR of $2,565.80.

     The division notes that the health care provider's calculation of the Medicare facility specific amount for this code, as stated in their position statement, was correct. The respondent's calculation was not correct. Although other factors in the payment calculation change annually with the calendar year, the wage index portion changes with the federal fiscal year. Services performed after October 1st of 2016 fall under federal fiscal year 2017—which runs from October 1st of the previous calendar year through September 30th of the fiscal year. As the disputed date of service falls on November 1, 2016, the payment calculation requires the use of the facility's wage index factor for FY 2017 in calculating the facility specific amount.

   - Procedure code 11760 has status indicator T denoting a significant procedure subject to multiple-procedure payment reduction. The highest paying status T procedure is paid at 100%; all others paid at 50%. This procedure is paid at 50%. This is classified under APC 5053, which, per OPPS Addendum A, has a payment rate of $428.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $257.20. This amount multiplied by the facility's annual wage index of 0.8026 yields an adjusted labor-related amount of $206.43. The non-labor related portion is 40% of the APC rate or $171.47. The sum of the labor and non-labor related amounts is $377.90. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment amount is $0. The total Medicare facility specific reimbursement, including multiple-procedure discount, is $188.95. This amount multiplied by 200% yields a MAR of $377.90.

   - Procedure code A9270 has status indicator E denoting excluded or non-covered codes — not payable on an outpatient bill. Payment cannot recommended.

   - Procedure code 93005 has status indicator Q1 denoting STVX-packaged codes — reimbursement is included in the package for any service with status indicator S, T, V or X; this code is not separately payable unless no other status S, T, V or X code is billed on the same claim. Reimbursement for this service is included in the payment for procedure codes 11760 and 26765 billed on the same claim. Separate payment is not recommended.

3. The total recommended payment for the services in dispute is $2,943.70. This amount less the amount previously paid by the insurance carrier of $2936.29, leaves an amount due to the requestor of $7.41.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7.41.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7.41, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.